

		FOR OHF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0040006</u></p> <p>Facility Name: <u>Rosewood Care Center of Elgin</u></p> <p>Address: <u>2355 Royal Boulevard</u> <u>Elgin</u> <u>60123</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(847) 888-9585</u> Fax # ()</p> <p>IDPA ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/5/1995</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2004</u> to <u>6/30/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) <u>Accountant's Compliance Report Attached</u> (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>Cindy A. Tefteller</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____		(Signed) <u>Accountant's Compliance Report Attached</u> (Date) _____	Paid Preparer	(Print Name and Title) <u>Cindy A. Tefteller</u>		(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
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SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,735	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF			11,002	11,002	8
9	SNF/PED					9
10	ICF	13,143	17,337		30,480	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,143	17,337	11,002	41,482	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.76%

D. How many bed-hold days during this year were paid by the Department?

155 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/4/1994

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/4/1994 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number

of beds certified 42 and days of care provided 11,002

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/2005 Fiscal Year: 6/30/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	211,727	23,212	11,352	246,291		246,291		246,291		1
2	Food Purchase		205,451		205,451		205,451	(3,832)	201,619		2
3	Housekeeping	158,245	33,505		191,750		191,750		191,750		3
4	Laundry	42,603	9,491		52,094		52,094		52,094		4
5	Heat and Other Utilities			161,369	161,369		161,369	6	161,375		5
6	Maintenance	27,543	12,274	156,453	196,270		196,270	(2,035)	194,235		6
7	Other (specify):* Sanitation			18,973	18,973		18,973		18,973		7
8	TOTAL General Services	440,118	283,933	348,147	1,072,198		1,072,198	(5,861)	1,066,337		8
B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800		9
10	Nursing and Medical Records	2,480,959	214,710		2,695,669		2,695,669		2,695,669		10
10a	Therapy	92,461	493	472,433	565,387		565,387	22,667	588,054		10a
11	Activities	58,961	3,640	2,310	64,911		64,911		64,911		11
12	Social Services	63,951		2,400	66,351		66,351		66,351		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,696,332	218,843	484,943	3,400,118		3,400,118	22,667	3,422,785		16
C. General Administration											
17	Administrative			683,000	683,000		683,000	(481,791)	201,209		17
18	Directors Fees										18
19	Professional Services			3,885	3,885		3,885	42,083	45,968		19
20	Dues, Fees, Subscriptions & Promotions			26,102	26,102	995	27,097	(9,221)	17,876		20
21	Clerical & General Office Expenses	171,176	40,960	26,618	238,754		238,754	181,801	420,555		21
22	Employee Benefits & Payroll Taxes			412,741	412,741		412,741	35,195	447,936		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,284	2,284	(995)	1,289		1,289		24
25	Other Admin. Staff Transportation			3,392	3,392		3,392	18,621	22,013		25
26	Insurance-Prop.Liab.Malpractice			73,568	73,568		73,568	18,948	92,516		26
27	Other (specify):*										27
28	TOTAL General Administration	171,176	40,960	1,231,590	1,443,726		1,443,726	(194,364)	1,249,362		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,307,626	543,736	2,064,680	5,916,042		5,916,042	(177,558)	5,738,484		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Rosewood Care Center of Elgin

#0040006

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,928	9,928		9,928	189,534	199,462			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							650,484	650,484			32
33	Real Estate Taxes			112,627	112,627		112,627		112,627			33
34	Rent-Facility & Grounds			1,623,876	1,623,876		1,623,876	(1,608,782)	15,094			34
35	Rent-Equipment & Vehicles			11,531	11,531		11,531		11,531			35
36	Other (specify):* Mortgage Insur.							222,467	222,467			36
37	TOTAL Ownership			1,757,962	1,757,962		1,757,962	(546,297)	1,211,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		289,000	50,641	339,641		339,641	(1,152)	338,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		289,000	126,744	415,744		415,744	(1,152)	414,592			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,307,626	832,736	3,949,386	8,089,748		8,089,748	(725,007)	7,364,741			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

Report Period Beginning: 7/1/2004

Ending: 6/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,407)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,448)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,152)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(425)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,755)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,982)	20		28
29	Other-Attach Schedule Marketing Salary	(71,300)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (92,469)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(632,538)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (632,538)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (725,007)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of Elgin

ID# 0040006

Report Period Beginning: 7/1/2004

Ending: 6/30/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (71,300)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(71,300)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Elgin

0040006 Report Period Beginning:

7/1/2004

Ending: 6/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,832)	0	0	0	0	0	0	0	0	0	0	(3,832)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	6	0	0	0	0	0	0	0	0	6	5
6	Maintenance	0	(37,654)	35,619	0	0	0	0	0	0	0	0	(2,035)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,832)	(37,654)	35,625	0	(5,861)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	22,667	0	0	0	0	0	0	0	0	0	22,667	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	22,667	0	0	0	0	0	0	0	0	0	22,667	16
	C. General Administration													
17	Administrative	0	(683,000)	201,209	0	0	0	0	0	0	0	0	(481,791)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	42,083	0	0	0	0	0	0	0	0	42,083	19
20	Fees, Subscriptions & Promotions	(9,737)	0	516	0	0	0	0	0	0	0	0	(9,221)	20
21	Clerical & General Office Expenses	(71,300)	0	253,101	0	0	0	0	0	0	0	0	181,801	21
22	Employee Benefits & Payroll Taxes	0	0	35,195	0	0	0	0	0	0	0	0	35,195	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	18,621	0	0	0	0	0	0	0	0	18,621	25
26	Insurance-Prop.Liab.Malpractice	0	6,659	12,289	0	0	0	0	0	0	0	0	18,948	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(81,037)	(676,341)	563,014	0	(194,364)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(84,869)	(691,328)	598,639	0	(177,558)	29							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Management Fee	\$ 683,000	HSM Management Services	100.00%	\$	\$ (683,000)
2	V	6 Repairs & Maintenance	37,654	HSM Management Services	100.00%		(37,654)
3	V	10a Therapy	472,433	Rosewood Therapy Services, Inc.	0.00%	495,100	22,667
4	V						
5	V	34 Rent	1,623,876	Elgin Real Estate, L.L.C.	0.00%		(1,623,876)
6	V	30 Depreciation		Elgin Real Estate, L.L.C.	0.00%	166,544	166,544
7	V	32 Interest		Elgin Real Estate, L.L.C.	0.00%	656,932	656,932
8	V	36 Mortgage Insurance		Elgin Real Estate, L.L.C.	0.00%	222,467	222,467
9	V	26 Property Insurance		Elgin Real Estate, L.L.C.	0.00%	6,659	6,659
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 2,816,963			\$ 1,547,702	\$ * (1,269,261)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 201,209	\$ 201,209
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	253,101	253,101
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	35,195	35,195
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	18,621	18,621
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	22,990	22,990
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	15,094	15,094
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	42,083	42,083
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	12,289	12,289
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	35,619	35,619
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	6	6
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	516	516
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 636,723	\$ * 636,723

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	1,129,468	3	7.48%	Salary	\$ 91,261	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00%	464,750	3	7.48%	Salary	37,552	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 128,813		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 Report Period Beginning: 7/1/2004 Ending: 3/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization HSM Management Services, Inc.
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	17	Salaries - Officers	Total Cost	18	\$ 1,723,032	\$ 1,723,032	6,505,170	\$ 128,813	1
2	21	Salaries - Others	Total Cost	18	2,976,309	2,976,309	6,505,170	222,508	2
3	22	Payroll Taxes	Total Cost	18	298,975		6,505,170	22,351	3
4	22	Employee Benefits	Total Cost	18	103,243		6,505,170	7,718	4
5	25	Travel	Total Cost	18	249,076		6,505,170	18,621	5
6	30	Depreciation	Total Cost	18	307,518		6,505,170	22,990	6
7	34	Building Rent	Total Cost	18	201,898		6,505,170	15,094	7
8	19	Professional Services	Total Cost	18	562,909		6,505,170	42,083	8
9	21	Telephone	Total Cost	18	173,318		6,505,170	12,957	9
10	26	Insurance	Total Cost	18	164,374		6,505,170	12,289	10
11	21	Taxes, License, & Ofc Sup	Total Cost	18	235,903		6,505,170	17,636	11
12	6	Maintenance	Total Cost	18	157,822		6,505,170	11,799	12
13	5	Heat & Other Utilities	Total Cost	18	77		6,505,170	6	13
14	20	Dues & Subscriptions	Total Cost	18	6,896		6,505,170	516	14
15	17	Direct - Admin	Direct Cost	1	72,396	72,396	1	72,396	15
16	17	Direct - Admin	Direct Cost	17	1,083,550	1,083,550	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	5,126		1	5,126	17
18	22	Direct - Payroll Taxes	Direct Cost	17	77,596		0	0	18
19	30	Direct - Depreciation	Direct Cost	1	0		1	0	19
20	30	Direct - Depreciation	Direct Cost	2	1,050		0	0	20
21	25	Direct - Travel	Direct Cost	1	0		1	0	21
22	25	Direct - Travel	Direct Cost	6	1,048		0	0	22
23	6	Direct - Maintenance	Direct Cost	1	23,820		1	23,820	23
24	6	Direct - Maintenance	Direct Cost	14	207,591		0	0	24
25	TOTALS				\$ 8,633,527	\$ 5,855,287		\$ 636,723	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Refinance Mortgage	Varies	10/2003	\$ 13,500,000	\$ 0	7/2004	Prm+1/4	\$ 34,199	1								
2	GMAC		X	Refinance Mortgage	\$77,227.00	8/1/04	14,522,200	14,403,456	9/1/2039	5.42%	684,135	2								
3	Less: Related Party Interest Income Offset																			
4	Interest Income										(88,098)	3								
5	Amortization of Loan Fees										26,696	4								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$77,227.00		\$ 28,022,200	\$ 14,403,456			\$ 650,484	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 28,022,200	\$ 14,403,456			\$ 650,484	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 222,467 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Rosewood Care Center of Elgin**# **0040006** Report Period Beginning: **7/1/2004** Ending: **6/30/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1.	Real Estate Tax accrual used on 2004 report.			\$	104,966	1																			
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	106,807	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	1,841	3																			
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	110,786	4																			
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																			
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																			
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	112,627	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2000	89,332	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2001	92,092	9																					
		2002	99,528	10																					
		2003	103,927	11																					
		2004	109,689	12																					
2003 Payment = \$51,963																									
2004 Payment = \$54,844																									
Accrual = 2004 remaining (54,845) + 1/2 estimated 2005 tax bill (55,941)																									

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040006

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-09-100-021</u>	<u>2355 Royal Blvd, Elgin</u>	<u>\$ 109,688.82</u>	<u>\$ 109,688.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 109,688.82	\$ 109,688.82

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006 Report Period Beginning:7/1/2004 Ending:6/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,268 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>206,817</u>	<u>1993</u>	<u>\$ 590,758</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	206,817		\$ 590,758	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006

Report Period Beginning:

7/1/2004

Ending:

6/30/2005**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	139		1994	\$ 4,829,673	\$	25-40	\$ 128,067	\$ 128,067	\$ 1,366,047	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Landscaping		1996	4,792		25	192	192	1,823	9
10	Hot Water Booster		1994	661		10	23	23	661	10
11	Building Sign		1994	1,827		10	59	59	1,827	11
12	Walk-in Cooler		1994	5,231		10	175	175	5,231	12
13	Salad Prep Sink		1994	1,966		10	63	63	1,966	13
14	Exhaust Hood		1994	7,104		10	240	240	7,104	14
15	Worktable with Sink		1994	1,003		10	35	35	1,003	15
16	Pot & Pan Sink		1994	3,053		10	104	104	3,053	16
17	Signage		1994	5,796		10	198	198	5,796	17
18	Addition to Phone System		1994	3,218		10	113	113	3,218	18
19	Interior Signs		1994	7,506		10	247	247	7,506	19
20	Windowsills/Panels		1994	818		10	25	25	818	20
21	Water Heaters		1994	3,162		10	107	107	3,162	21
22	Water Heater		1994	1,283		10	45	45	1,283	22
23	Emergency Generator		1994	27,491		10	917	917	27,491	23
24	Carpet		1994	7,303		10	245	245	7,303	24
25	Wallpaper/Painting		1994	76,500		10	2,550	2,550	76,500	25
26	Telephone		1994	7,550		10	252	252	7,550	26
27	Shower Room Repairs		2002	5,600		10	560	560	1,493	27
28	Seal Parking Lot		2004	7,536		2	2,826	2,826	2,826	28
29										29
30	Leasehold Improvements - Facility:									30
31	Painting		1998	16,105	2,300	7	2,300		15,983	31
32	Door Repairs		1998	4,778	683	7	683		4,607	32
33	Mini Blinds/Wallcovering/Wallpaper		1999	6,187	884	7	884		5,402	33
34	Carpeting		1999	10,413	1,487	7	1,487		8,834	34
35	Continued on Additional Page									35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Drapes	2000	\$ 10,234	\$ 1,462	7	\$ 1,462	\$	\$ 7,676	37
38	Computer Cabling	2000	2,392	342	7	342		1,566	38
39	Carpet	2003	3,450	493	7	493		1,068	39
40	Painting/Wallcovering	2003	4,295	614	7	614		1,329	40
41	Flooring	2004	7,994	1,142	7	1,142		1,906	41
42	Patching and Replacing Wallcovering	2005	5,000	178	7	178		178	42
43									43
44									44
45	Leasehold Improvements - Management Company:								45
46	Office Construction/Improvements	1995	572		5			572	46
47	Office Design	1995	52		5			52	47
48	Office Shelving	1996	122		4			122	48
49	Office Expansion	1996	540		4			540	49
50	Office Expansion	1997	1,446		3			1,446	50
51	Office Expansion	1998	816		3			816	51
52	Office Addition	1999	403		3			403	52
53	Door Locks	1999	201		3			201	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,084,073	\$ 9,585		\$ 146,628	\$ 137,043	\$ 1,586,362	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 744,620	\$ 343	\$ 40,649	\$ 40,306	5-10 Yrs	\$ 673,156	71
72	Current Year Purchases	24,799		1,565	1,565	5-10 Yrs	1,565	72
73	Fully Depreciated Assets	54,499					54,499	73
74								74
75	TOTALS	\$ 823,918	\$ 343	\$ 42,214	\$ 41,871		\$ 729,220	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 47,781	\$	\$ 10,620	\$ 10,620	4 Yrs	\$ 21,891	76
77										77
78										78
79										79
80	TOTALS			\$ 47,781	\$	\$ 10,620	\$ 10,620		\$ 21,891	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12L, if applicable)	\$ 6,546,530	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)	\$ 9,928	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)	\$ 199,462	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)	\$ 189,534	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)	\$ 2,337,473	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Total Units	Total Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-8	hrs	\$	17,078	\$	148,237	\$			17,078	\$	148,237	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		2,267		49,003				2,267		49,003	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a-8	hrs		22,649		297,860		493		22,649		298,353	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39-8	# of prescripts						262,721				262,721	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Ambulance, Laboratory, X-Ray Other (specify): & Enterals	39-8					50,641		26,279				76,920	13
14	TOTAL			\$	41,994	\$	545,741	\$	289,493		41,994	\$	835,234	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

Report Period Beginning: 7/1/2004

Ending:

6/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2005

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (682,420)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 120,000)	1,441,234		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,446		6
7	Other Prepaid Expenses	3,978		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 783,238	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	73,245		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(50,263)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,982	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 806,220	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 214,033	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	197,320		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,009		31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,786		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	54,000		35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	75,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 684,148	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 684,148	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 122,072	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 806,220	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 115,082	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 115,082	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	229,790	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(222,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 6,990	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 122,072	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,761,472	1
2	Discounts and Allowances for all Levels	(2,301,376)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,460,096	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,001,074	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,001,074	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,400	13
14	Non-Patient Meals	3,407	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,807	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,448	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,448	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	1,152	28
28a	Miscellaneous Income	461	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,613	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,475,038	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,072,198	31
32	Health Care	3,400,118	32
33	General Administration	1,443,726	33
B. Capital Expense			
34	Ownership	1,757,962	34
C. Ancillary Expense			
35	Special Cost Centers	339,641	35
36	Provider Participation Fee	76,103	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,089,748	40
41	Income before Income Taxes (line 30 minus line 40)**	385,290	41
42	Income Taxes	(155,500)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 229,790	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Rosewood Care Center of Elgin**

0040006

Report Period Beginning: **7/1/2004**

Ending:

6/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,938	2,056	\$ 63,268	\$ 30.77	1
2	Assistant Director of Nursing	2,057	2,182	63,002	28.87	2
3	Registered Nurses	33,249	35,274	914,887	25.94	3
4	Licensed Practical Nurses	13,863	14,708	312,837	21.27	4
5	CNAs & Orderlies	80,781	85,700	1,033,065	12.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,298	5,621	92,461	16.45	8
9	Activity Director					9
10	Activity Assistants	4,972	5,274	58,961	11.18	10
11	Social Service Workers	3,871	4,107	63,951	15.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,576	22,890	211,727	9.25	15
16	Dishwashers					16
17	Maintenance Workers	2,261	2,399	27,543	11.48	17
18	Housekeepers	16,724	17,742	158,245	8.92	18
19	Laundry	5,046	5,354	42,603	7.96	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,667	12,378	171,176	13.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,954	5,256	93,900	17.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,257	220,941	\$ 3,307,626 *	\$ 14.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	455	\$ 11,352	1-3	35
36	Medical Director	Contract	7,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	130	2,310	11-3	43
44	Activity Consultant	120	2,400	12-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	705	\$ 23,862		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ Section N/A		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
													Improvement Type
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006Report Period Beginning: 7/1/2004Ending: 6/30/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$7,956
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 72,943 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 76,103
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,407
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER OF ELGIN INC.
RECLASSIFICATIONS
MEDICAID COST REPORT
06/30/05

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL & SEMINARS	(995)	24
DUES, SUBSCRIPTIONS & PROMOTIONS TO RECLASS IDPH LICENSE	995	20

ROSEWOOD CARE CENTER OF ELGIN INC.
IDPH ID #0040006
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2005

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 3,392</u>
	<u>\$ 3,392</u>

**ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS
SUBMITTED WHICH WERE LESS THAN \$250.00 EACH

ROSEWOOD CARE CENTER OF ELGIN, INC.
IDPH ID #0040006
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2005

RELATED NURSING HOME:

CITY:

ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

TYPE OF BUSINESS:

HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
ELGIN REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY